

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 2425

FEB 25 1941

Registration District No. 266

Primary Registration District No. 5373

Registrar's No. 7

1. PLACE OF DEATH:

(a) County Dent  
(b) City or town Franklin Typ  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
XX /  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution XXXX (Specify whether  
In this community all her life  
years, months or days)

8. (a) PRINT FULL NAME Margaret Malinda Wells

8. (b) If veteran, name war XX 3. (c) Social Security No. XX

4. Sex female 5. Color or race white 6. (a) Single, widowed, married, 2 divorced widowed  
6. (b) Name of husband or wife Sylvester Wells 6. (c) Age of husband or wife if alive X years  
7. Birth date of deceased July 25 1853  
(Month) (Day) (Year)

8. AGE: Years 87 Months 5 Days 25 If less than one day hr. min.

9. Birthplace Ill (City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business ----

MOTHER FATHER { 12. Name Joe Bryant  
13. Birthplace Don't Know (City, town, or county) (State or foreign country)  
14. Maiden name Anna Welch  
15. Birthplace Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant Rose M. Miller  
(b) Address Doss MO

17. (a) burial (b) Date thereof Jan 21 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cem

18. (a) Signature of funeral director W. H. H. H.

(b) Address Salem MO

19. (a) 1-21-41 (b) W. H. H. H.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent 33  
(c) City or town Franklin Typ 0  
(If outside city or town limits, write "RURAL")  
(d) Street No. XX (If rural, give location) 0  
(e) If foreign born, how long in U. S. A. XXXX years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 20  
year 1941 hour 4 minute 10 P.M.

21. I hereby certify that I attended the deceased from Nov  
20, 1940, to Jan 20, 1941;  
that I last saw her alive on Jan 19, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia  
Lobar R & L  
Due to Influenza  
Due to 20

Other conditions 20  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations ✓  
Of autopsy ✓

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) ✓  
(b) Date of occurrence ✓  
(c) Where did injury occur? ✓  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place)  
While at work? 24 Means of injury 24

23. Signature W. H. H. H. (M. D. or other) 1  
Address Salem MO Date signed 1-21-41

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 5,

District File Number 241269

Date Filed \_\_\_\_\_

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~by~~ \_\_\_\_\_

\_\_\_\_\_, Registered Apprentice No. \_\_\_\_\_

working under my personal supervision.

Signed \_\_\_\_\_

Wm. W. McDonald

Licensed Embalmer No. \_\_\_\_\_

3806

P. O. Address \_\_\_\_\_

Salem, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.